

Medical practice: Defendants and prisoners

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It is argued in this paper that a doctor cannot serve two masters. The work of the prison medical officer is examined and it is shown that his dual allegiance to the state and to those individuals who are under his care results in activities which largely favour the former. The World Health Organisation prescribes a system of health ethics which indicates, in qualitative terms, the responsibility of each state for health provisions. In contrast, the World Medical Association acts as both promulgator and guardian of a code of medical ethics which determines the responsibilities of the doctor to his patient. In the historical sense medical practitioners have always emphasized the sanctity of the relationship with their patients and the doctor's role as an expert witness is shown to have centred around this bond. The development of medical services in prisons has focused more on the partnership between doctor and institution. Imprisonment in itself could be seen as prejudicial to health as are disciplinary methods which are more obviously detrimental. The involvement of medical practitioners in such procedures is discussed in the light of their role as the prisoner's personal physician.

The legal and penal characteristics of any country will be central determinants of its character, and the opinions discussed here are a critique of the relationship between medical practice and these functions of society. Although most contributors would wish to present their views as a model of objectivity, the present author considers that it is important to discuss the effect of prejudice at an early stage. Eysenck (1960 and 1972) has shown that an individual's attitudes can be represented on two ideological axes, one representing conservatism/radicalism and the other tough mindedness/tender mindedness. He also suggested that certain attitudes cluster. Thus support of the death penalty and flogging, as well as a belief in the harsh treatment of criminals, would characterize the tough-minded conservative. Contrasting attitudes also group together: belief in the tenets of pacificism, that the death penalty is barbaric and that attention should be directed to the cure of prisoners, these are the views of the tender-minded liberal. To present both sides of an argument and come to a conclusion which is apparently reasoned can disguise bias. Later in this paper the doctor's role in disciplinary pro-

cedures will be discussed. This could be done from two viewpoints: the first would be that of the doctor preventing those who are manifestly unfit for punishment from being punished; the corollary is of course that the doctor also selects those who are fit for punishment. The two views evoke contrasting sentiments and ultimately the choice of which is argued with more force will depend on the attitudes of the observer.

The role of the doctor in society

Durkheim (1957) described the doctor as a 'centre of moral life' but similar idealized views have been challenged by Titmuss (1968) who argued that, at least in recent history, this is a romanticized belief, for most doctors' altruism was limited and they were largely employed through the auspices of clubs and companies. In Britain most medical practitioners are contracted to serve the interests of individuals, while maintaining a varying degree of responsibility to their employer the state. The vast majority of their work is of no concern or importance to the rest of society but occasionally the doctor finds himself as interlocutor between the individual and the state. In that situation the doctor's first concern can be his relationship with his patient or alternatively he can take the view that benefit of the individual is secondary to that of society as a whole. Other practitioners are contracted to the state or to the institutions of society but they do not undertake to provide simultaneously a personal medical service. Thus a medical practitioner employed by a large company can, in the interests of his employer, provide information on an applicant's or employee's health which is disadvantageous to that individual; however, such a doctor does so with the patient's consent and he does not additionally act as personal physician to that person. It seems quite ethical therefore for a doctor to have divided loyalties as long as his patient appreciates both the full implications of the situation and also has the opportunity to be treated by a doctor who does not have such a dual role.

The relationship between the individual and the state

Consideration of the relationship between the

individual and the state has been of great importance in the development of political thought and the introduction of a third party, in the case of the doctor, to this equation adds a further complication. Aristotle argued that the 'felicity' of the state was the same as that of the individual although it is difficult to understand how the prescription of a uniform solution could unify conflicting and disparate interests. 'Hence it is clear that the same life which is best for individuals is also best for states and for mankind at large' (see Warrington, 1959).

In 1790 Edmund Burke published a denunciation of the French Revolution which was in turn criticized by Thomas Paine who attacked Burke and supported the revolutionaries. Paine reaffirmed the French National Assembly's declaration which recognized that although individuals derived power from the state, the state's function was solely in the service of the individual. He described government as nothing more than a national association acting in the principles of society; he appealed to those whose conscience was stirred by the legal barbarity of the state and advocated reform thus:

'There lies hidden from the eye of common observation, a mass of wretchedness that has scarcely any other chance, than to expire in poverty or infamy. Its entrance into life is marked with the pressage of its fate; and until this is remedied, it is in vain to punish' (see Seldon, 1906).

Paine's statements, which preceded the publication of John Howard's work, were remarkable for their determinism and for directing attention to prevention rather than towards a punitive course.

More than sixty years later Mill (1859) was to consider the principles by which an individual could be deprived of his freedom and his argument, which was the basis of his work, *On Liberty*, is particularly pertinent to this discussion.

'The object of this Essay is to assert one very simple principle, as entitled to govern absolutely the dealings of society with the individual in the way of compulsion or control, whether the means by physical force in the form of legal penalties, or the moral coercion of public opinion. That principle is, that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number is self-protection. That is the only purpose for which power can be rightly exercised over any member of a civilised community, against his will, is to prevent harm to others.'

These quotations represent only fleeting glimpses of the ancient dialectic between the individual and the state; in fact the continuing resolution of this disputation could be seen as the fulcrum around which society has developed. Campbell (1975), in acknowledging the reformatory influence of Mill's utilitarian philosophy, has argued that there is a link between these ideals and the development of the

welfare state. The innate conservatism of the medical profession meant that it became involved in this reform, reluctantly and almost by default; it was a time when it became imperative to extend into the prisons the advances which had been made in public health and preventive medicine.

The Hippocratic oath

There is a popular but falsely held belief that medical practitioners are bound by the Hippocratic oath. Singer (1928) described this grand ethical monument as a series of classical aphorisms which were clearly designed for a youth entering an apprenticeship. It is quoted in part here because of the important influence which it continues to exert on both the practice of medicine and, more importantly, the expectations of the public.

'The regimen I adopt shall be for the benefit of the patients according to my ability and judgment, and not for their hurt or for any wrong. I will give no deadly drug to any, though it be asked of me, nor will I counsel such, and especially I will not aid a woman to procure abortion. Whatsoever house I enter, there I will go for the benefit of the sick, refraining from all wrongdoing and corruption, and especially from any act of seduction, of male or female, of bond or free. Whatsoever things I see or hear concerning the rights of men, in my attendance on the sick or even apart from them, which ought not to be noised abroad, I will keep silence thereon, counting such things to be as sacred secrets. Pure and holy will I keep my Life and Art.'

This uniquely client-orientated professional code must have added an important part to the practitioner's charisma in times when his therapeutic capabilities were otherwise severely limited. It emphasized the sanctity of the relationship between the physician and his patient so that not only his health but also his secrets and sexuality were respected by the physician. The oath is only concerned with the doctor-patient relationship and does not offer guidelines for the other aspects of a medical practitioner's work. In its support of a total commitment to the patient it introduces a potential area of conflict for it does not allow for the possibility of balancing apparently divergent interests. Thus for the contemporary practitioner, who is made increasingly aware of his responsibilities to society, the oath can prove to be an unwanted reminder of the halcyon days when his patients' interests were his only consideration. In the present context it is important to emphasize the oath's implicit respect for the patient's expectations and confidences and it would seem to follow that it is unethical not to warn an individual if the doctor is not acting in all respects as his personal physician.

Although the medical profession rarely espoused movements for political and social change some of its practitioners formed close relationships with

defendants whom they tried to protect from the rigours of the law.

Doctors and defendants

For several millennia some lunatics have not been punished for crime (Clark, 1944) on humanitarian grounds rather than as a result of special pleas. This rule was not universal, however, for under Roman law (Jolowicz, 1952), a man was held responsible for his acts irrespective of his state of mind. Amongst other factors the spread of Christianity is said to have influenced understanding of the relationship between insanity and criminal responsibility (Bromberg, 1965). The Church was experienced in the management of madness but the newly developing legal system found its definition difficult and it only recognized a crude association between mental disorder and criminal acts. In the thirteenth century Bracton (see Woodbine, 1915) wrote of an assessment of reason which has been described as the 'wild beast test' whereby 'an insane person is one who does not know what he is doing is lacking in mind and reason and is not far removed from the brutes.'

Three hundred years later Fitzhubert described a test for mental subnormality: 'An idiot is such a person who cannot account or number 20 pence, nor tell who was his father or mother, nor how old he is' (see Michael *et al*, 1941).

In 1671 Sir Mathew Hale applied Bracton's maxim as an exclusive test whereby demented felons were exempted from capital punishment because of their lack of understanding and reasoning as well as the similarity between their behaviour and that of the beasts. Hale also described partial insanity of mind, a concept which Walker (1968) has shown to have exercised legal, medical and political minds for three centuries. The death penalty, and the large numbers of offences to which it applied as punishment, was probably responsible more than any other factor for the urgency of the inquiry into concepts of insanity and criminal responsibility.

In May 1800, Hadfield shot at King George III in Drury Lane theatre and medical evidence was called to testify at his trial. In spite of the fact that he did not satisfy the criteria of Hale's 'right/wrong' test, he was acquitted and his case was the occasion for the hasty passing of the Criminal Lunatics Act which was to facilitate his disposal.

'If any person indicted for any offence shall be insane, and shall upon arraignment be found so to be by a jury, lawfully empanelled for that purpose so that such person cannot be tried on such indictment, it shall be lawful for the court before whom any such person is brought to be arraigned to direct such finding to be recorded, and there upon to order such person to be kept in strict custody until His Majesty's pleasure shall be known' (see Criminal Lunatics Act 1800).

Because ecclesiastical courts were defunct, madness was no longer seen as an affliction of Divine Providence and this new law was designed to be interpreted in the light of advice from medical practitioners so their presence in court became indispensable. Expert medical witnesses were called not only to diagnose insanity but to explain its ramifications and relation to morality and if such pleas were accepted the accused was spared. McNaghten's case in 1843 was to further enhance the responsibilities of medical practitioners in court. Evidence was given on the relationship between mental illness and McNaghten's responsibility for the illegal act; he was found not guilty on the grounds that he was incapable of distinguishing between right and wrong at the time of the offence. The press led an outcry at this defence of 'partial insanity' but the House of Lords ruled that: 'It must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.'

These concepts of responsibility were intimately connected with the legal preoccupation with *mens rea*, that is, criminal intent. As medicine and psychiatry flourished the expert witness grew in authority but he was later criticised for putting forward contentious and idiosyncratic views in the guise of established medical fact. Norwood East's (1927) advice that the psychiatrist should have limited responsibilities in court was a model of objectivity; 'His concern would seem to end when he has faithfully given his evidence. The result such evidence may ultimately have on the patient is the concern of others'. The crown later found it necessary to call its own witnesses who were employed to advise and represent the interests of the state. Before the abolition of the death penalty legal battles centred around an expert who firmly sided with the accused and was party to the submission of a defence, or pleas of insanity, whereas it was left to the prosecution and its representatives to press for a finding of guilt (see Matheson (1958), 42 CrAppR 145, and Din (1962), 42 CrAppR 116, quoted by Walker, 1968).

Mentally abnormal offenders: Prevalent legislation

The way in which legislation is used to deprive a mentally disordered person of his liberty has been the subject of much contemporary criticism (for example, Gostin, 1975). An obverse and often disregarded aspect relates to the responsibilities which are associated with the proper and legal exercise of these powers. Titmuss (1968) showed that, together with other professional groups, doctors have increasingly become arbiters of the

welfare state. By diagnosing need and rejecting or selecting for individual services they apply the strictures or benefits which are made available to individuals by society. In relation to mentally disordered offenders it has recently been argued that legislation is now underused, rather than overused and that many are deprived of treatment to which they have a statutory right (Bowden, 1975). Some have said that this is due to prejudice (Bennett, 1973) and lack of resources (Gunn, 1974) but Titmuss (1958) believed that it was part of a process of the disengagement of medical practice from the poor and he predicted an ultimate decline in the ethical component of the medical services. The above observations would seem to refute some of Illich's (1975) assertions. He foresaw a threefold danger in the extension of modern methods of treatment: specific functional or organic iatrogenic disorders, mutual doctor/patient dependence, and lastly a situation in which health expenditure deprives other services of facilities which would have a more advantageous effect on health. The withdrawal of psychiatric, and particularly asylum, facilities from certain groups has not resulted in an improvement in their condition since there has been no compensatory increase in the investment in other services; neither do we know what the effects of such an increase in resources would have been. It is the neglect of those Acts which continue to protect the mentally disordered from the processes of the law which is a cause for concern to the courts (Ormrod, 1975) and to the Prison Medical Service (Report of the Work of the Prison Department, 1973) and so raises important ethical questions.

The prison medical service

In 1777 John Howard described the barbarism to which those who were imprisoned were subjected. Amongst other proposals he suggested that a chaplain and a physician should be appointed to each prison, no doubt because of their potentially humanizing influence. Because the major problems at that time related to virulent epidemics of contagious disease the Act which shortly followed the publication of Howard's work was designed to extend advances made in public into the prisons (Act for Preserving the Health of Prisoners and Preventing the Gaol Distemper, 1774). A legacy of this early and vital concern with public health has been that the prison medical service has concentrated more on the public health aspects of its work at the expense of a parallel development of personal medical services of a type which have flourished outside penal institutions. The Insane Prisoners Act 1840 made it possible for insane convicts to be transferred to local asylums; those who were most difficult to handle were contained in Dartmoor and later Millbank. In 1863 Broadmoor was opened as a criminal lunatic asylum and in the latter part of the

nineteenth century there was an increasing awareness of the overrepresentation of mental disorder in prisoners.

Besides the public health aspects of his work the prison medical officer also supervised punishment procedures as can be adduced from the following:

'Rule 87 Dietary punishment shall not be inflicted on any prisoner, nor shall he be placed in close confinement, nor shall corporal punishment be inflicted, unless the medical officer has certified that the prisoner is in a fit condition of health to undergo the punishment.

Rule 88 All corporal punishment shall be attended by the Governor and the medical officer. The medical officer shall give orders for preventing injury to health as he may deem necessary.

Rule 89 Punishment in the case of a prisoner over 18 years of age shall be inflicted either with a cat-o'-nine-tails or with a birch rod' (see Rules and Standing Orders for the Government of Local Prisons, 1911).

While such supervision benefited some prisoners, in that it excluded the unfit from punishment and prevented irremedial injury to those who were punished, it also protected the state from embarrassment due to any overzealousness in its agents. The medical officer could presumably overrule the Governor, though only on medical grounds, and he would, after a flogging, tend the wounds which he himself had authorized.

Following the passing of the Inebriates Act (1898) state reformatories were set up at Aylesbury and Warwick for drunkenness offenders. The Radnor Royal Commission paved the way for the Mental Deficiency Act 1913 which recognized the connexion in certain individuals between antisocial conduct and mental defect. Because punishment had little or no deterrent effect on these individuals it proposed that permanent institutional care be made available for defectives under local authority supervision. In 1919 a full-time prison medical officer was appointed to Birmingham with a new remit, to investigate the mental state of those on remand and to report to the court as to whether treatment or punishment were appropriate. The appointee, Hamblyn-Smith, was noticeably one of the few medical practitioners who came to be known as a penal reformist. He stressed the harmful effects of imprisonment on certain offenders and stated that treatment, whose success depended largely on the patient's cooperation, was not possible in individuals imprisoned against their will (Hamblyn-Smith, 1922). This view has been ignored and a decade later Norwood East and Hubert (1939) recommended an extension of the then currently popular analytic techniques for the benefit of a selected group of criminals.

Gray (1973) has outlined the services which were available in 1972 for the treatment of a daily average population in excess of 38 000 in 111 prisons and

borstals. There were 100 full-time prison medical officers, four consultant psychiatrists holding a joint appointment with the National Health Service and Prison Service and 55 visiting 'psychotherapists' attending 24 clinics on a sessional basis. An average of 18 per cent of the population were undergoing treatment at any one time. Prison medical officers provided a psychiatric report on 11 953 persons remanded in custody for investigation, they volunteered reports for 1005 individuals and made a report on the state of physical health in 518 persons (Report of the Work of the Prison Department, 1972). Ninety-eight part-time practitioners assisted in the medical care of the 100 000 annual admissions. In crude terms this was recently the extent of the prison medical service. However, in addition to his role as a medical practitioner to the prisoners and his public health work it will be shown later that another important aspect of the prison medical officer's work is related to the total institution in which he functions and its relationship to the state.

International medicine and health ethics

An examination of the complementary development of the World Medical Association and World Health Organisation shows that there has been a division of purpose: the World Medical Association has confined itself to the provision of a code of individual ethics while the World Health Organisation has concentrated on the state's responsibility to provide an adequate standard of health care.

In 1947 the World Medical Association elaborated a modern version of the Hippocratic oath, known as the 'Declaration of Geneva'. One year later the 'Universal Declaration of Human Rights' was adopted and proclaimed by the General Assembly of the United Nations. Article 5 reads: 'No one shall be subjected to torture or cruel, inhuman or degrading treatment or punishment.'

GUIDELINES FOR PRISON MEDICAL OFFICERS

The 'Standard Minimum Rules for the Treatment of Prisoners' was adopted by the first United Nations Congress on the Prevention of Crime and the Treatment of Offenders in 1958. Several clauses are worthy of consideration:

'22(1) The medical services should be organized in close relation to the general health administration of the community or nation.'

'25(1) The medical officer shall have the care of the physical and mental health of the prisoners.'

'25(2) The medical officer shall report to the director whenever he considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment.'

'32(1) Punishment by close confinement or re-

duction of diet shall never be inflicted unless the medical officer has examined the prisoner and certified in writing that he is fit to sustain it.'

'32(3) The medical officer shall visit daily prisoners undergoing such punishments and shall advise the director if he considers the termination or alteration of the punishment necessary on the grounds of physical or mental health.'

'33 Handcuffs and straight jackets shall not be used except in the following circumstances: on medical grounds by the direction of the medical officer.'

These guidelines clearly reflect the bipartisan nature of the interests of the United Nations, that of the individual prisoners and of the state. Thus clauses 25(1) and 32(1) above contain assertions which are essentially contradictory in that it is not possible to be responsible for the physical and mental health of a prisoner and also to sanction his punishment, on the grounds that he is fit to receive it, by methods which may be prejudicial to health. Although it might be proper for a medical practitioner to function in either role, as physician-arbiter or physician-healer, it was obviously not appropriate for him to act in both capacities and this conflict was recognized by the World Health Organisation who invited the World Medical Association to provide an international code of medical deontology since it did not believe that it was a competent body to propose or endorse an international code of medical ethics.

A recent United Nations publication, *Health aspects of avoidable maltreatment of prisoners and detainees* (1975), states that medical ethics are considered to be the rules of personal conduct governing the professional relationships of physicians with their patients or with each other. These rules normally require that the sole object of the physician's intervention shall be to promote or safeguard the physical and mental health of his patient and the United Nations has endorsed the view that the World Medical Association should have special responsibility in this field of medical ethics. This report quotes a clause from an act of the National Council on Crime and Delinquency of Canada which was said to reflect aptly the World Medical Association's remit: 'A prisoner retains all the rights of an ordinary citizen except those expressly, or by necessary implication, taken from him by law.'

In contrast the World Health Organisation expressed the belief that its own relation to the ethical implications of health was better expressed by the term 'health ethics' which referred to the accountability of governments to their populations in regard to health matters. The World Health Organisation's constitution names one simple objective: 'the attainment by all peoples of the highest possible level of health.' This implies that member governments have an ethical obligation to

protect their subjects from procedures which offer a deliberate threat to physical or mental health, and, in particular, the World Health Organisation emphasized that prisoners should have access to the best facilities for medical care that it was feasible to provide. This concern with the health ethics of the management of prisoners is reflected in a recent resolution of the Committee of Ministers of the Council of Europe who reaffirmed the 'Standard Minimum Rules for Prisoners'. Section 32(1) states: 'Punishment by disciplinary confinement and any other punishment which might have an adverse effect on the physical or mental health of the prisoner shall only be imposed if the medical officer has examined the prisoner and certified in writing that he is fit to sustain it' (see Resolution 5, Standard Minimum Rules for the Treatment of Prisoners, B(73)42, 1973).

The World Medical Association has since reaffirmed its concern with the relationship between the prison medical officer and the prisoner as his patient. After approval by the Council of the World Medical Association in March 1975 a statement recommended to the World Medical Assembly held in Tokyo later that year for adoption as the Declaration of Tokyo. Two of its clauses stated that:

'5) A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible.

'6) Where a prisoner refuses nourishment and is considered by the doctor as capable of forming a rational judgment concerning the consequences of such a voluntary refusal of nourishment, he shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgment shall be confirmed by at least one other independent doctor. The consequence of the refusal of nourishment shall be explained by the doctor to the prisoner.'

From the above discussion it is clear that the World Medical Association and the World Health Organisation have developed contrasting but complementary ideologies. The World Health Organisation recognized quite early in its history that it could not adequately develop an acceptable and universal system of medical ethics; it designated this aspect of deontology to the World Medical Association. Documents published since by the respective organizations have in some areas offered contradictory guidelines for practice and we have obviously not yet reached that ideal situation which was foreseen by Aristotle in which the wellbeing of the individual and the state is congruous. If a criminal offence is committed, the offender becomes liable to punishment; imprisonment is one form of punishment and its purpose is clear: 'Punishment by the state not for the purpose of affording compensation or restriction but as a penalty for the offence and in order to deter the commission of similar offences and in some cases for the reform of the offender' (Harris, 1973).

Standing Orders and Prison Rules

The Prison Rules (1964) describe the purpose of imprisonment as 'training and treatment' with the purpose of assisting prisoners 'to lead a good and useful life.' The prison medical officer who works in a legal punishment establishment finds himself in a uniquely divisive position, acting on behalf of a total institution and yet with the responsibility for the individual prisoners who are under his care. The institution itself makes particular demands because some of its activities are related to national security. Practices within penal establishments are governed by Standing Orders and Prison Rules; access to the former is restricted by the Home Office. Staff have to struggle against forces which institutionalize themselves as well as the tendency to respond to external criticism by providing mutual uncritical support for the threatened member in the way that has been described by Goffman (1961). The medical officer is aware of the disproportionately high social, physical and mental morbidity of his prisoner patients; similarly their 'spoiled identity' (Goffman, 1963) is particularly obvious. Medical officers also sign the Official Secrets Acts (1911 and 1920) Declaration which emphasizes that they are liable to prosecution if they publish (in a speech, lecture, on radio or television, in the press or a book, either orally or in writing) any information which they may acquire without official sanction. The declaration warns that the consequences following a breach of the provisions may be serious and even if this Act were repealed it is not clear how much medical officers would still be bound by civil service rules.

Prison medical officers' responsibilities

In any attempt at job description it is difficult to list its qualitative aspects. Although a categorization of items of service is possible it results in an artificial and somewhat distorted view of a person's work whereas in reality emphasis on different aspects will vary. Given these qualifications it is important to attempt to look at the prison medical officer's responsibilities to see if they reflect the differing demands which are made of him.

ACTIVITIES FAVOURING THE DOCTOR/PATIENT RELATIONSHIP

The prisoner is treated for any physical illness, will receive adequate nourishment and be kept in as equitable an environment as is practicable at the direction of the medical officer. The doctor makes special arrangements for the transfer, reception and treatment of sick prisoners and can arrange for rehabilitation and treatment on release. Many individuals therefore receive medical treatment which would be unavailable to them as free individuals because of the disorganization of their lives and, as in any institution, the isolation and treatment

of infective and contagious disease is extremely important.

ACTIVITIES SUPPORTING THE INSTITUTION

The medical officer advises what type of penal establishment a prisoner is likely to tolerate physically and mentally and he assesses suitability for work and physical education. The doctor has some functions which are only concerned with the maintenance of security: he decides as to the strength of escort necessary in the transfer of individuals on whom a detention order has been made under the Mental Health Act and he also advises as to whether restraint (closeting chain and cuffs) is necessary when a prisoner is taken outside prison for examination or treatment. Another important medical function is that of assessing fitness to undergo disciplinary procedures, although the fact that such close surveillance is required implies that these procedures offer a threat to health. Thus the medical officer establishes the fitness of prisoners to undergo cellular confinement for report or punishment and gives authority for the use of the loose canvas restraint jacket. Under the exceptional circumstances of a death penalty being passed for treason the medical officer is still required to furnish the executioner with necessary information as to the height and weight of the prisoner, his general condition, age, and whether he is likely to offer any resistance.

ACTIVITIES SUPPORTING THE STATE

The medical officer informs the prison governor of any particular point of which he may become aware, as a result of examination, in regard to the person of any prisoner which may assist in identifying him. If a prisoner is examined by a doctor on behalf of the defence, the Director of Public Prosecutions, the Director and Regional Principal Medical Officer are informed and the medical officer advises as to whether a further medical opinion on behalf of the crown is necessary. An interesting example of the priority which can be given to serving the state's interests is seen in the treatment of drug addicts. Their particulars, as is mandatory on any doctor, are forwarded to the Home Office and to the Director of the Prison Medical Service for statistical purposes. Only on receipt of the prisoner's written consent should the fact of his addiction be disclosed to his general practitioner.

Discussion

Clause 22(1) of 'Standard Minimum Rules for the Treatment of Prisoners', which was quoted earlier, states that 'the medical services should be organized in close relation to the general health administration of the community or nation'. The Butler Committee (Report of the Committee on Mentally Abnormal Offenders, 1975) has commented that there have

been consultant appointments held jointly between the National Health Service and the Prison Medical Service where the essential linkage between services has not taken place; this was attributed largely to the continuing isolation of the Prison Medical Service. The dangers inherent in this division are obvious, for Titmuss (1968) has warned that a separate state system for a minority group tends to become a poor standard system recruiting the worst rather than the best categories of staff and, if the quality of personal service is low, there will be less freedom of choice and more felt discrimination. A closure of the division between the National Health Service and the Prison Medical Service would also offer the prisoner some choice of doctor. The National Health Service Act 1946, section 33 (2b), states that individuals have the right to choose the practitioner by whom they are attended. This right is not extended to sentenced prisoners although it is not clear by what law it is denied them.

Three clauses of the Declaration of Geneva illustrate the dilemma which faces the prison medical officer: 'The health of my patient will be my first consideration'; and 'a doctor shall preserve absolute secrecy on all he knows about his patient because of the confidence entrusted in him', and the following practice is deemed to be unethical: 'Collaboration in any form of medical service in which the doctor does not have professional independence.'

Professional independence is of course inextricably bound up with the economics of health care and what treatments are available at any one time will be related to a complex system of priorities. Even outside prisons there are evident disparities in services available in different regions and between services themselves. This inequitable distribution of care is compounded by the way in which facilities and practitioners select patients who suit themselves or their service and reject the misfits, as has been described by Bennett (1973) in the context of community health services. Therefore the services available to prisoners reflect the practice of medicine outside these institutions; all other services select suitable cases for treatment—the prisons cannot. These considerations of health ethics should be the concern of the state and doctors cannot be held responsible for those restrictions which are imposed on their practice because of political and economic expediency.

It has been noted elsewhere that discomfort and hardship are clearly matters which any person involved in crime, under ordinary conditions, will suffer and that is accepted as not only inevitable but permissible (see Report of the Committee of Privy Counsellors, 1972). It would obviously be wrong to challenge the ethical position of any practitioner who makes a contract to provide his services to any organization which functions legally. However, the passive participation of physicians in procedures

which are detrimental to health is questionable. This position was well illustrated in a description of the cooperation of medical practitioners in depth interrogation (Compton Report, 1971), which was later shown to result in physical and mental injury and was declared to be illegal (Report of the Committee of Privy Counsellors, 1972). In a penal context the ethics of a medical practitioner's involvement in disciplinary procedures is doubtful since the very processes of punishment deprive the prisoner of his right to conditions favourable to health.

Much of the prison medical officer's concern with aspects of public health is time-consuming and relates largely to the institution; they could be taken over by medical practitioners who were only contracted to the state and did not have the additional, and competing, function of providing individual medical care. Perhaps to a greater degree than elsewhere, the prisoner as a person needs to see his doctor as someone who is concerned only with his health and wellbeing and who would represent his interests against those of the institution if it were necessary. If a group of prison medical officers were only serving this function, they could concern themselves more with the development of a liaison between extrapenal health and welfare services and their prisoner patients.

That it is possible for doctors to withdraw from their role of supervising and giving authority to practices which favour the state can be seen if the subject of forced feeding is examined. In 1911, 'Standing Orders for the Government of Local Prisons' stated:

Rule 287 In the event of a prisoner refusing to take food, the medical officer must consider the advisability of compulsory feeding in an early state, in order that weakness of a serious character may not ensue. Although discretion must rest with the medical officer, even forty-eight hours, as a general rule would appear to be an exceptionally long period, and a limit which should not be exceeded unless there are good medical reasons for doing so.'

This rule was obviously intended to deal with fast-ing suffragettes and the prison medical officer was expected to begin forced feeding within 48 hours of the first refusal of food. A similar restriction of the doctor's independent practice by directive can be seen in other rules concerning forced feeding which were effective up to 1969 and which appear to protect the state from the injudicious forced feeding of individuals who could be released from prison.

'Should a prisoner who is being treated under Rule 166 (convicted in colonial courts) and Standing Order 231 (amelioration of penal conditions in certain cases) refuse food, full details will at once be submitted to the Commissioners for the decision of the Secretary of State, as to whether the provisions of the Prisoners (Temporary Discharge for Ill-Health) Act, 1913, shall be applied, and the medical

officer will not resort to artificial feeding until the decision is communicated to him.'

The present position is reflected in the Declaration of Tokyo which was quoted earlier and which represents a dramatic change of policy. This was brought about as a result of a directive from the Home Secretary which said that it was not necessary to force-feed individuals whom the medical officers considered to be capable of forming a rational judgment about their predicament.

Conclusions

Under the Official Secrets Acts (1911 and 1920) information which may be prejudicial to the safety or interests of the state is censored. However, these Acts can be used to suppress any informed criticism of the penal system. By their very nature prisons exist outside the community and this separateness fosters an inward-looking defensiveness; they are understaffed and overcrowded with inmates (Report of the Work of the Prison Department, 1974). The work of the prison medical officer is particularly difficult because of the strictures which are imposed on practice in prisons and because of the continuing struggle which must be exercised against the processes of institutionalization. To the prisoner, the doctor is sometimes seen as merely a facilitator of the process of punishment and this experience will perhaps colour his attitudes to the medical profession and the way in which he is able to use it, both within and outside the penal setting.

The prison medical officer is responsible for all aspects of the prisoners' health, both personal and social. The personal aspects of health care should be provided by doctors who are employed by the National Health Service and have contacts with extrapenal health and welfare facilities. For certain subspecialities of medicine, eg, psychiatry and general practice, experience in prison medical practice would be an invaluable experience and would additionally provide an exchange of ideas and opinion.

The frequency of medical examination could be reduced if the charges which such checks serve to rebut were dispelled. Thus, tuberculosis poses a continued threat in prisons not only because of its incidence in the newly imprisoned but also because gross overcrowding makes infectious disease a more serious health hazard. Reports for court on those remanded on less serious charges could be done by training psychiatrists and probation officers who could provide treatment or supervision outside prison; individuals on more serious charges would be seen by more experienced staff. Those aspects of medical practice which were related to the public health aspects of prisons and medical administration would continue to be served by prison medical officers who were contracted to the Home Office. Such doctors would not be involved in the personal

aspects of health care.

These proposals would facilitate the establishment of two levels of medical practice within prisons, as exists outside. One group of doctors employed by the National Health Service would provide a personal health service for prisoners: they would be governed by a system of medical ethics. Another group would concentrate on the administrative aspect of health care and would be employed by the Home Office as civil servants. The two groups would be linked by a common profession but they would have contrasting functions and interests. A dialectic would emerge which would result in continuing and critical self assessment and, hopefully, development. This process can only occur between individuals: it cannot exist within an individual because the demands of the institution and prisoner are overwhelming but divergent, and an individual copes with this conflict by the psychological defence mechanism of repression. In such a situation it is most often of course the prisoner's interests which are restrained.

There is a conflict between medical ethics and health ethics which cannot be resolved by the appointment of an individual as guardian of both. Provision of a separate and independent health service to prisoners should be made which should be intimately linked with extrapenal facilities.

Two rare insights into the way in which a prison medical officer sees himself and his work have been provided by recent writers (Prewer, 1974; Topp, 1976) whose contributions emphasize the disparity between their views and those which have been expressed in this paper. Prewer (1974) believes that the prison doctor accepts the basic principle that society has two duties to those in captivity: to provide them with good hygienic conditions; to care for them when they are sick. He states that excessive complaint in prisoners is no indication of ill health but represents unnecessary worry about their physical conditions, fear that they will not survive to enjoy their release, boredom, a desire to avoid work, to seek attention, air grievances, extract concessions or merely to meet men from some other part of the prison. Prewer compares prison medicine with military and aviation medicine and expresses the hope that it will not be merged with the National Health Service and he admits that he has become 'complexionally superannuated from the bold and courageous thoughts of youth and fervent years'. His contribution closes thus:

'One thing is quite certain, and that is that medicine in its wider sense is going to play a larger part in both the treatment and control of those offenders who come into penal institutions, be they many or be they few; and in this context, it is suggested that treatment and control are merely two sides of the same coin.'

Topp (1976) states that 'unproductive boundary antagonisms are likely to occur' because the prison

medical officer is not fully and completely accepted by his National Health Service colleagues as possessing equal specialist skills. He states that the appointment and recognition of consultant forensic psychiatrists by the Home Office and Department of Health and Social Security gives such individuals the freedom to believe that they alone have priority and expertise in this field while prison medical officers, who lack such official blessing, are rather 'unceremoniously placed in the hierarchy of professionalism'.

Forensic psychiatry has been described by the Forensic Section of the Royal College of Psychiatrists as the application of the principles of general psychiatry to that part of the population which comes into direct contact with legal processes either in criminal or civil actions. Forensic psychiatrists are also said to be concerned with the management of behaviour disorders in settings where management is difficult and specialized methods of treatment may be required (*British Journal of Psychiatry*, 1975). Most consultant psychiatrists are involved in the forensic aspects of psychiatry (Bowden, 1976) and within the special hospitals and prisons the custodial aspects of forensic medicine have been practised for more than a century. However, the organization of forensic psychiatry as a subspeciality of psychiatry within the National Health Service is a relatively new phenomenon which will influence existing services as well as developing its own characteristics. The rift between the prison medical service and the National Health Service has been discussed by the Butler Committee (1975) and by Topp (1976). Proposals are made in this paper which would bring the services closer together and improve the personal medical service available to prisoners.

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